Exhibit K

NYSIF New York State Insurance Fund

January 25, 2005

DIMARTINO FARMS
57 PLAINS RD
WALDEN , NY 12586

Injured Employee:Daniel Beltempo
Accident Date: 01/21/05
Carrier Case No.49697683 096

Dear James

Thank you for your time and assistance in reporting the above-referenced accident to the State Insurance Fund on 1/25/05 . Enclosed for your records is a copy of the C-2 which was created from the report you provided on the phone. If there are any discrepancies in the information entered on the C-2, please notify our office by phone at 1-877-467-3863.

If you have any questions or concerns regarding coverage or benefits for the above-referenced claim, please call our Claims Team at between 8:30 AM and 4:30 PM.

Sincerely, William J Liberio

Customer Service Department

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD

EMPLOYER'S REPORT OF WORK-RELATED ACCIDENT/OCCUPATIONAL DISEASE

Send this notice directly to the Chair, Worker's Compensation Board at the address shown on the reverse side within ten days after an accident occurs. **ANSWER ALL QUESTIONS FULLY.** A copy should also be provided to or retained by your workers' compensation insurance carrier.

Any employer who fails to timely file Form C-2, as required by Section 110 of the Workers' Compensation Law, is subject to a fine of not more than $1000. In addition, the Board or Chair may impose a penalty of up to $2500.

TYPEWRITER PREPARATION IS STRONGLY RECOMMENDED - INCLUDE ZIP CODE ON ALL ADDRESSES - EMPLOYEE'S S.S. NO. MUST BE ENTERED BELOW

WCB CASE NO (If Known)	CARRIER CASE NO	CODE NO	WC POLICY NO.	DATE OF ACCIDENT	EMPLOYEE'S S.S. NO.
	49597683- 098	W204002	11737947	01/21/05	111509287

1. (a) EMPLOYER'S NAME DIMARTINO FARMS	(b) EMPLOYER'S MAILING ADDRESS 57 PLAINS RD WALDEN , NY 12586	(c) OSHA CASE/FILE NO.
(d) LOCATION (If Different From Mailing Address)	(e) NATURE OF BUSINESS (Principal Products, Services, etc.)	(f) NYS U.I. EMPLOYER REG. NO.

2. (a) INSURANCE CARRIER THE STATE INSURANCE FUND	(b) CARRIER'S ADDRESS 15 COMPUTER DRIVE W., ALBANY, NY 12205	
3. (a) INJURED EMPLOYEE (First, M.I., Last) DANIEL BELTEMPO	(b) ADDRESS (Include No. & Street, City, State, Zip & Apt. No.) 52 OLD UNIONVILLE RD WALLKILL , NY 12589	(c) PHONE 845-566-4948

ACCIDENT

4. (a) ADDRESS WHERE ACCIDENT OCCURED 8967 ST RTE9 CHAZY , NY 12921	(b) COUNTY CLINTON			(c) WAS ACCIDENT ON EMPLOYER'S PREMISES? NO
5. HOUR EMP. BEGAN WORK 10:00AM	6. TIME OF ACCIDENT 4:45 PM	7. DEPT WHERE REGULARLY EMPLOYED	8. (a) DATE STOPPED WORK BECAUSE OF THIS INJURY/ILLNESS 01/21/05	(b) WAS INJURED PAID IN FULL FOR DAY? YES

INJURED PERSON

9. SEX MALE	10. (a) AGE 49	(b) DATE OF BIRTH 1/3/56	11. OCCUPATION (Specific job title at which employed) DRIVER	12. DATE HIRED 08/16/04
13. (a) AVERAGE EARNINGS PER WEEK 600			(b) TOTAL EARNINGS PAID DURING 52 WEEKS PRIOR TO DATE OF ACCIDENT (Include bonuses, overtime, value of lodging, etc.)	
14. (a) PART OF FULL TIME EMPLOYEE? FULLTIME			(b) INJURED EMPLOYEE'S WORK WEEK (Indicate days of week usually worked) M-F	

NATURE OF INJURY

15. NATURE OF INJURY AND PART(S) OF BODY AFFECTED HEAD	16. (a) DID YOU PROVIDE MEDICAL CARE? YES	(b) IF YES, WHEN? 01/21/05
17. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? YES	18. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN INPATIENT? NO	
19. (a) NAME AND ADDRESS OF DOCTOR	(b) NAME AND ADDRESS OF HOSPITAL CVPH MEDICALCENTER 75 BEEKMAN ST PLATTSBURGH , NY 12901	
20. (a) HAS EMPLOYEE RETURNED TO WORK? NO	(b) IF YES, DATE	(c) AT WHAT WEEKLY WAGE?

NOTE: FORM C-11 MUST BE FILED EACH TIME THERE IS A CHANGE IN EMPLOYMENT STATUS

CAUSE OF ACCIDEN

21. WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific, identify tools, equipment or material the employee was using.)

CLT LOADED HIS TRUCK AT CHAZY ORCHARDS DROVE ONE MILE SOUTH AND PULLED TO THE SIDE OF THE ROAD TO CHECK REFRIGERATION ON THE TRUCK. CLT WAS ON THE TRUCK ON THE DRIVER SIDE OF SLEEPER TRYING TO START REFRIGERATION UNIT AND FELL OFF THE TRUCK HIT HEAD ON THE ROAD . A PASSENGER CAME BY AND HELP CLT.
A FIRE COMPANY RESPONDED TO ACCIDENT. CLT WAS TRANSFERRED FROM CVPH TO FLETCHER ALLEN HOSPITAL BURLINGTON , VT.

22. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use separate sheet if necessary.)

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23. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE, e.g., the machine struck against or which struck him/her, the vapor or poison inhaled or swallowed, the chemical that irritated his/her skin. In case of strains, the thing (s)he was lifting, pulling, etc.

FATAL CASES	24. (a) DATE OF DEATH	(b) NAME/ADDRESS OF NEAREST RELATIVE	(c) RELATIONSHIP

PREPARATION

DATE EMPLOYER/SUPERVISOR FIRSTKNEW OF INJURY 01/21/05	DATE OF THIS REPORT 1/25/05	IF FORM IS SUBMITTED BY EMPLOYER, COMPLETE A&B BELOW. IF FORM IS SUBMITTED BY THIRD PARTY, COMPLETE A, B, C & D BELOW.
A. EMPLOYEE PREPARING FORM OR SUPPLYING INFORMATION TO THIRD PARTY JAMES SLAUGHTER	B. TITLE GM	TELEPHONE NO. & EXTENSION 845-629-4105
C. IF REPORT PREPARED BY THIRD PARTY, COMPANY NAME AND ADDRESS		
D. THIRD PARTY CONTACT NAME BILL LIBERIS		TELEPHONE NO. & EXTENSION